CHIROPRACTIC ORDER FORM

SCHEDULING
P: 407.741.5400
F: 407.629.6096
E: FLscheduling@rayusradiology.com
O Maitland O Orlando O Oviedo
O MetroWest O Orlando (Turkey Lake) O Winter Park

SCHEDULING
P: 352.753.2660
F: 352.753.2259
E: FLscheduling@rayusradiology.com
O Lady Lake

If faxing an order, please include:
- Demographics
- Insurance card
- Clinical notes

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See back for addresses

O Patient will call to schedule O Call patient to schedule

Appointment date and time	Check-in time	Patient DOB	O M O F
Patient name (as shown on insurance card)	Primary phone #	Secondary phone #	
Insurance name	Insurance ID #	Pre-authorization #	
O Auto O Workers' comp O Letter of protection	Date of injury	Attorney information	

(REQUIRED) Written diagnosis/reason/symptom for exam(s). Must include **specific** clinical indications (such as location, context and severity) to support medical necessity for each test.

Is the exam/procedure related to an injury? O No O Yes **If yes** O Initial O Subsequent or O Sequela

MRI

O IV contrast as clinically indicated by radiologist OR O No contrast

NEURO
- O Brain
  - O Traumatic brain atrophy
- O Lumbosacral plexus (includes piriformis)
- O Sacrum and sacroiliac joints
- O Sacrum/coccyx

SPINE
- O Cervical
- O Thoracic
- O Lumbar

MUSCULOSKELETAL
- O Extremity joint _____
  - O L O R O BIL
- O Extremity non-joint _____
  - O L O R O BIL

OTHER
- O X-ray to rule out metal
- O _____

MRI spine interpretations will be performed by a subspecialized spine radiologist and **Stephen Fridinger, DC, DACBR**, or **Timothy J. Mick, DC, DACBR, FICC**.

If you prefer, you may request:
- O MD read only **OR**
- O Chiropractic read (includes MD read)

CT

O IV contrast as clinically indicated by radiologist OR O No contrast

SPINE
- O Cervical
- O Thoracic
- O Lumbar
- O Extremity joint _____
  - O L O R O BIL
- O Extremity non-joint _____
  - O L O R O BIL
- O Site _____
- O Other _____

SPINE & JOINT INJECTION(S)

Diagnostic and therapeutic injection consultation and treatment. Treatment may include:

- O Epidural steroid injection
  Site _____
- O Facet joint injection
- O Facet nerve injection
- O Selective nerve block
  Site _____
- O SI joint arthrography with therapeutic injection
- O Trigger point injection
- O Arthrogram with therapeutic injection
  Site _____
- O Arthrogram, diagnostic with MR or CT to follow
- O Other _____

X-RAY

Views _____

- O Cervical
- O Cervical flexion/extension
- O Cervical - Davis w/obliques
- O Thoracic
- O Lumbar
  - O Standing
  - O Recumbent
- O Lumbar w/obliques
- O Lumbar flexion/extension
- O Scoliosis screening
- O Pelvis
- O Ribs O L O R O BIL
- O Shoulder O L O R O BIL
- O Elbow O L O R O BIL
- O Wrist O L O R O BIL
- O Hand O L O R O BIL
- O Hip O L O R O BIL
- O Knee O L O R O BIL
- O Ankle O L O R O BIL
- O Foot O L O R O BIL
- O Other _____

Previous medical imaging Date and location _____
Condition is due to a recent trauma? O No O Yes (briefly explain) _____
Indicate (re: cancer) O History of, or O Current
Lab results Creatinine* _____ Blood draw date _____
**Lab values needed within 90 days of the exam for IV contrast if the patient 1) is diabetic, 2) is having chemotherapy 3) is 70 years or older or 4) has renal impairment*

REPORTING METHOD O Report only O Report & images O Report & CD O Phone report _____ O Rax report _____

Provider name (print)		Phone #
Provider signature (required) Do not use rubber stamp.	**NPI # (required for new providers)**	Date

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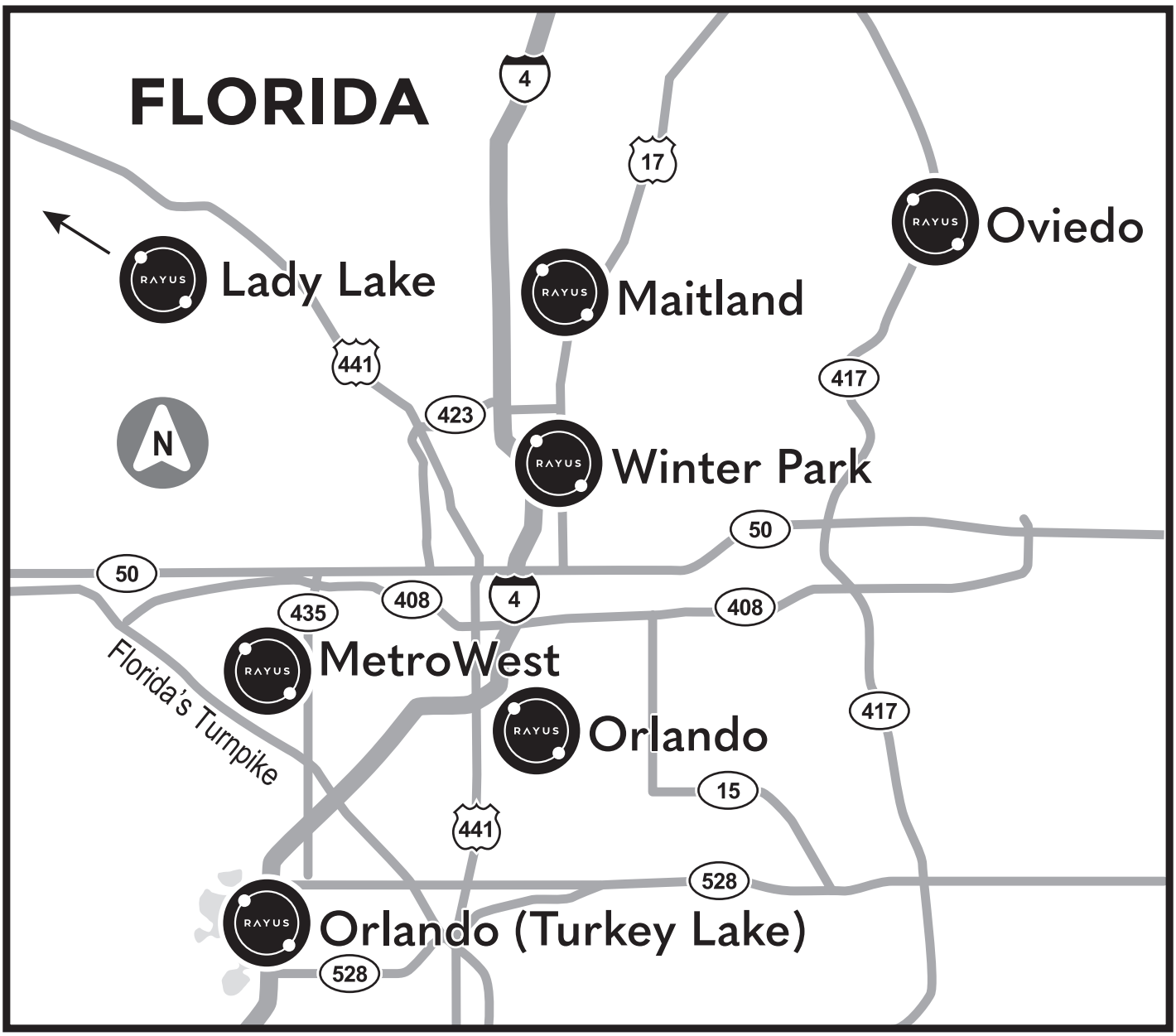

LADY LAKE
809 CR 466, Suite 400
Lady Lake, FL 32159

MAITLAND
1640 N. Maitland Ave., Suite 1020
Maitland, FL 32751

METROWEST
1781 Park Center Dr., Suite 110
Orlando, FL 32835

ORLANDO
3847 Oakwater Cir.
Orlando, FL 32806

ORLANDO (TURKEY LAKE)
9350 Turkey Lake Rd., Suite 100
Orlando, FL 32819

OVIEDO
1000 W. Broadway St., Suite 104
Oviedo, FL 32765

WINTER PARK
964 S. Orlando Ave.
Winter Park, FL 32789